Access Rehab Centers
A Waterbury Hospital & Easterseals Partnership in Physical Rehabilitation

Please print legibly and bring all pages to your first appointment.

PATIENT INFORMATION

Client's Name: _____ DOB: _____
Address: _____ Home Phone: _____
Address 2: _____ Work Phone: _____
City, State, Zip: _____ Cell Phone: _____

Are you receiving care for injuries from a **Motor Vehicle Accident**? ❑ No

❑ Yes – Date of Accident is ____/____/____ and what STATE did the accident occur in? _____
I have given Access Rehab Centers information regarding my Auto Insurance.
I, ☐ do not have medical insurance ☐ do not wish to give Access Rehab this information.
I understand that my auto/workers comp. insurance may not pay for my services, in which case I will be responsible to pay for these services. I understand that my medical insurance carrier may have prior authorization or timely filing requirements and by not providing this information in advance, Access Rehab Centers will be unable to fulfill these requirements. I am instructing Access Rehab Centers to bill my: ☐ Auto Insurance ☐ Own account-I am responsible for paying.

Do you carry **MED PAY** on your Automotive Insurance Policy? ❑ No

❑ Yes – Auto Carrier Name & Phone: _____
Attorney Name & Phone: _____

Are you receiving care for injuries relating to a **Workers Compensation Case**? ❑ No

❑ Yes – Date of Injury is ____/____/____ and Claim Number _____
I have given Access Rehab Centers information regarding my Workers Comp Insurance.
I, ☐ do not have medical insurance ☐ do not wish to give Access Rehab this information.
I understand that my workers compensation insurance may not pay for my services, in which case I will be responsible to pay for these services. I understand that my medical insurance carrier may have prior authorization or timely filing requirements and by not providing this information in advance, Access Rehab Centers will be unable to fulfill these requirements. I am instructing Access Rehab Centers to bill my: ☐ Workers Comp carrier ☐ Own account-I am responsible for paying.

Are you receiving care for injuries relating to a **Liability Claim?** ❑ No
(NOT Motor Vehicle or Workers Comp)?

❑ Yes – Date of Injury is ____/____/____ and
Attorney Name & Phone: _____

Are you receiving **Home Care**? ❑ No

❑ Yes – Agency Name & Phone: _____

Do you have **Medical Insurance**? ❑ Yes *(skip to next question)*

❑ No, I **do not have medical insurance**, have exhausted my benefits, my insurance does not cover my services at Access Rehab or I do not wish to use my insurance. In the case of a high deductible plan, I understand that by not
billing my insurance, charges will not be applied to my deductible. If insurance is billed and service is denied, I will pay the rates established by the insurance company.

My services are not related to any type of accident and there is no attorney involved. Discounted fees do not apply to charges that are being billed to an attorney.

☐ I agree to pay at each visit: $95 for an evaluation; $75 for each therapy session; $55 for each Group therapy session.

☐ I agree to be billed: $100 for an evaluation; $80 for each therapy session; $60 for each Group therapy session.

Do you have a **Letter of Protection**? ❑ No *(skip to next question)*

❑ Yes, I have provided Access Rehab Centers with a Letter of Protection from my attorney to replace any other third party carrier. I do NOT have:

☐ Medical Insurance ☐ Workers Comp Insurance
☐ Auto Insurance ☐ I prefer not to use any Insurance

Payment will be made by my attorney when my case is settled. If I withdraw my case or if it is not successful, I will be responsible for payment for my services at Access Rehab Centers. I acknowledge that prior authorization or timely filing limits will not be fulfilled at that time.

INSURANCE INFORMATION

Guarantor Name: _____

Address: _____

City, State, Zip: _____

Relationship: _____

Insurance Plan Benefits for: _____

Your insurance carrier will be contacted by our office and when you arrive for your evaluation, the receptionist will have your benefits (i.e.: Deductible, Co-Pay, Coinsurance, Treatment days allowed this calendar year, etc.)

We will ask you to verify this information with your insurance carrier, as we are not responsible for any incorrect information your carrier has relayed to us.

If you have a Co-Pay, please bring your payment to each visit.

Any balance will be billed or refunded to me. **_____** (Patient's Initials)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY ...

CANCELLATION / ATTENDANCE POLICY

Should you need to cancel or re-schedule your appointment, please contact us at least 24-hours prior to your scheduled appointment. Missed appointments or cancellations with less than 24-hour notice will result in a $20.00 charge. If you miss two (2) consecutive appointments, or a total of three (3) appointments in total, your name will be taken off the schedule and your physician will be informed. A new referral from your physician will be required for you to continue treatment. If you are on Worker's Compensation, your employer will also be notified. If you are late for an appointment, your therapist will see you as the schedule permits.

PATIENT AGREEMENT AND INSURANCE BENEFITS

PERMISSION FOR GENERAL CARE: I hereby consent to diagnostic and treatment procedures that may be performed on me during my visit at Access Rehab Centers. These procedures are provided under the direction of my referring physician and other physicians involved in my care. I understand that Access Rehab Centers will occasionally accept students of therapy professions and that these students may be involved in observing or rendering services under the direction of a licensed therapist.

AUTHORIZATION TO PAY BENEFITS: I hereby assign benefits to include major medical, private insurance or any other plan to Access Rehab Centers. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I have been informed of the payment policies of Access Rehab Centers. I HAVE PROVIDED Access Rehab Centers with my insurance information and I understand that the benefits quoted to them may include benefits already used by me. I am responsible for being aware of the benefit limitations of my insurance. PLEASE NOTE: BENEFITS, IF VERBALLY QUOTED BY INSURANCE COMPANIES, ARE NOT CONSIDERED A GUARANTEE OF PAYMENT.

FINANCIAL AGREEMENT: In consideration of the services rendered by Access Rehab Centers at my request and directions, I agree to pay in full, within thirty (30) days of the date of billing, any portion of the bill that is deemed to be my responsibility. If it is necessary for Access Rehab Centers to engage in Attorney or Collection Agency to collect the balance due, I agree to pay lawful and reasonable attorneys collection fees and court costs. In addition, I authorize the release of medical records to the collection agency, collection attorney and/or their agents for collection purposes.

PAYMENT REQUEST FOR MEDICARE/MEDICAID: I certify that the information given by me in applying for payment under TVIIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Medicare/Medicaid Program, its intermediaries, or professional review organization, any information needed for this or a related Medicare/Medicaid claim. I authorize payment of benefits be made on my behalf.

PROTECTED HEALTH INFORMATION: I consent to the user or disclosure of my protected health information by Access Rehab Centers to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Access Rehab Centers may include HIV/AIDS related information, psychiatric and other behavioral health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which require that I provide specific authorization. I understand that information regarding how Access Rehab Centers will use and disclose my information may be found in Access Rehab Centers' Notice of Privacy Practices. I understand that consent is effective for as long as Access Rehab Centers maintains my protected health information.

CONSENT FORM FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

The undersigned patient, consent to have Access Rehab Centers use and disclose my protected health information, including, if applicable, drug/alcohol abuse, HIV and psychiatric information for the purposes of my treatment, healthcare operations and payment by the payer(s) of my health care benefit.

In addition, I consent for Access Rehab Centers to disclose my protected health information to the following for the following:

- Primary Care or referring Physician for follow-up care.
- To other providers for coordination of care.
- To other providers for referral and discharge planning**.**

I have been provided with Access Rehab Center's Notice of Privacy Practices and understand that I have the right to review this notice before signing this consent. I understand that Access Rehab Centers reserves the right to change its privacy practices, described in its Notice, and that if I wish to receive notification of any changes to the Notice, I may contact Access Rehab Centers' Patient Service Representative at the clinic where I receive care or go to Access Rehab Center's web site at www.accessrehabcenters.com.

I understand that I have the right to refuse signing this consent. If I refuse to sign this consent, Access Rehab Centers may provide me with treatment; however, I will be responsible for charges incurred at the time of service. I understand that treatment required by law, such as emergency care will be provided to me whether or not I sign this consent.

Unless I object, Access Rehab Centers may disclose protected health information of a general nature to my family or other individuals personally involved in my care, including changes in my condition.

I have the right to request that Access Rehab Centers restrict how they use and/or disclose my protected health information for the purpose of providing treatment, obtaining payment and/or conducting health care operations. Access Rehab Centers is not required to agree to any restriction I request. If Access Rehab Centers does decide to agree to my request, Access Rehab Centers must honor the restriction placed on the use and/or disclosure of my health information. I also understand that I have the right to request confidential communications by alternate means or locations. However, Access Rehab Centers may deny the request if it determines that it would be administratively difficult to comply with my request.

I understand that with respect to drug/alcohol abuse, HIV and psychiatric information, this Consent will expire 365 days after the date appearing below or 365 days after my final treatment, whichever is later. I also understand that I have the right to revoke this consent by notifying Access Rehab Center's Patient Service Representative at the clinic where I receive care in writing. I understand that if I revoke my consent, there will be no effect on uses and disclosures already made in reliance on my prior consent.

HIV RELATED INFORMATION: In the event that information released constitutes confidential HIV related information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION: In the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS: In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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PATIENT / GUARDIAN AGREEMENT

☑ I authorize release of information requested by my insurance plan for payment.

☑ I understand that I am financially responsible for any balance due.

☑ I have had the opportunity to have my questions answered regarding Access Rehab Centers' privacy practices.

☑ I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations.

☑ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

Be sure to bring all pages to your first visit/evaluation. Thank you.

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Appointment Reminder Consent

For

Client Name: _____

Complete this form and sign below to acknowledge and give permission for Access Rehab Centers to provide automatic Appointment Reminders for the above mentioned client, via:

- ❑ Email to: _____
- ❑ Text Message to Cell Phone # _____

Note: We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders.

❑ ALLTel	❑ G C I	❑ Sprint PCS
❑ AT&T	❑ Illinois Cellular	❑ T Mobile
❑ Bluegrass Cell	❑ Metrocall	❑ US Cellular
❑ Boost Mobile	❑ MetroPCS	❑ Verizon
❑ C Spine	❑ Nextel	❑ Virgin Mobil
❑ C Spine Wireless	❑ Pioneer Cellular	❑ Xfinity
❑ Cell Com	❑ Qwest	❑ Xfinity Wireless
❑ Cingular	❑ Silverstar	
❑ Cricket Wireless	❑ Simple Mobile	❑ _____

By signing below, I understand that normal text messaging rates may apply, and I am responsible for these related charges.
I will contact Access Rehab Centers if any above information should change.

_____ _____
Signature of Patient or Guardian Date

NOTE:
If you wish to stop the current Phone Call Reminders, please listen to the next message you receive and choose the "OPT OUT" option.

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MEDICAL HISTORY / EMERGENCY INFORMATION
CONFIDENTIAL

Client's Name: _____ **DOB:** _____

Primary Care Physician: _____ **Phone:** _____

Referred By: _____

In an emergency, who should we contact to make medical decisions?

Name: _____
Phone: _____
Relationship: _____

MEDICATION PROFILE (Include prescriptions, non-prescriptions, herbal supplements, vitamins, inhalers, eye drops, etc.)

❑ Not taking any medications

MEDICATION	DOSAGE	FREQUENCY	PHYSICIAN PRESCRIBING	PHONE NUMBER

❑ See addendum for additional Medications

ALLERGIES/REACTIONS (Include any allergies or reactions you may have.) ❑ No Known Allergies

_____

_____

_____

Please check Yes or No for each:

	YES	NO		YES	NO		YES	NO
High Blood Pressure			Heart Attack			Pacemaker		
Diabetes			Seizures			Epilepsy		
Stroke			Arthritis			Cancer		
Asthma			Broken Bones			Dizziness		
Headaches			Osteoporosis			Lung Disease		
Tuberculosis			HIV+/AIDS			Hepatitis		
Joint Replacement			Metal Implants			Bladder Trouble		
Psychiatric Care			*For Woman Only*: Could you be pregnant now? ❑ Yes ❑ No					
Other:								

Please list hospitalizations/surgeries/pertinent procedures.

❑ No Hospitalizations/Surgeries/Procedures

	When did this happen?
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

❑ See addendum for additional Hospitalizations/Surgeries/Procedures.

Please share any additional information that would be helpful to our staff:

_____

_____

_____

_____

Signature of Person Completing Form Date

_____

Reviewed By Date

Be sure to bring all pages to your first visit/evaluation. Thank you.